San Bernardino County Mental Health Plan

ACTION APPEAL FORM

FORM TO BE COMPLETED BY ***CONSUMER*** AND FORWARDED TO THE ACCESS UNIT

268 West Hospitality Lane, San Bernardino, CA 92415-0026

Consumer Name: _____ Date: _____

Using Authorized Representative: Yes ☐ No ☐ If "Yes," Name: _____

Date of Birth: _____ Gender: _____ Preferred Language: _____

Home Address: _____

_____ Telephone: _____

Clinic or Provider: _____

Did you receive a Notice of Action? Yes ☐ No ☐
Did you receive an action as defined as one of the following?

1. Denies or limits authorization of a requested service, including the type or level of service;
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;
4. Fails to provide services in a timely manner, as determined by the MHP or;
5. Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

If yes:
How Would You Like The Access Unit to review the Action?

_____

_____

_____

Consumer's Signature: _____ Date: _____

Once you have completed this Appeal form, a staff member from the Access Unit will contact you to discuss your concerns. In order to help resolve your appeal, Access Unit staff may need to discuss your concerns with other individuals. These other individuals might include your service provider, your provider's supervisor, or administrators within the Department of Behavioral Health. In order to allow the Access Unit staff to discuss your appeal with these other individuals, we need to obtain your written permission to release information about your appeal.

As the beneficiary/designee, you have the right to the following:

- To be treated with dignity and respect
- To file an appeal orally or in writing
- To ask for assistance with the appeal process
- To authorize another person to act on your behalf
- To select a provider as his/her representative in the appeal process
- To present evidence and allegations of facto or law, in person as well as in writing
- To not be subjected to discrimination or any other penalty for filing an appeal

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Appeal Signature Form

Authorization to Release Confidential Information

I hereby authorize the staff of the Access Unit of the Department of Behavioral Health to release information contained in my appeal, as well as information obtained in the course of conversations with me about my appeal, to other members of the staff of the Department of Behavioral Health and/or contracted facilities of the Department such as Inpatient Hospitals/IMD facilities. The disclosure of this information is required in order to (1) assist in achieving a resolution of my appeal, and (2) help the Quality Improvement Program of the Department of Behavioral Health prevent similar problems from occurring in the future.

Date:_____ **Signed:**_____